

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445481	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2013
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NAME OF PROVIDER OR SUPPLIER

ASBURY PLACE AT KINGSPORT

STREET ADDRESS, CITY, STATE, ZIP CODE

100 NETHERLAND LANE
KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to notify the physician in a timely manner of a Registered</p>	F 157	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p>11/11/13</p> <p>F 157 The physician was notified of the Registered Dietitian recommendation for Res. #6 and the rate adjustment was made on the tube feeding. Res. #6 has had no additional weight loss to date.</p> <p>The Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will review all charts for Registered Dietitian recommendations before November 30, 2013. The process to ensure that all Registered Dietitian recommendations are reviewed by the physician in a timely manner has been revised. The process change includes the Registered Dietitian</p>	11/30/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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100 NETHERLAND LANE
KINGSPORT, TN 37660

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F 157	<p>Continued From page 1</p> <p>Dietician's recommendation for one resident (#6) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on August 30, 2013, with diagnoses including Aspiration Pneumonia, Dysphagia, Anemia, Hypertension, Status Post Colostomy.</p> <p>Medical record review of a Nutritional Assessment dated September 3, 2013, revealed the resident was 5' 3" tall and weighed 117 lbs. (pounds), had an Ideal Body Weight of 115 lbs. received nothing by mouth, and received tube feedings of Glucerna 1.2 at 55 ml (milliliters) per hour twenty-four hours per day, with saline flushes of 50 ml four times a day.</p> <p>Medical record review of a Registered Dietician (RD) note dated September 25, 2013, revealed "wt (weight) loss from 117.3 lbs to 102.6 lbs 9/22/13. Wound on sacrum. Recommend to increase TF (tube feeding) rate to 65ml/hr (65 milliliters per hour) continuous. This would increase calories to 1872/24 hrs. Water flush 100ml q (every) 4 hrs. Goal = stop wt loss."</p> <p>Medical record review revealed no documentation the physician had been notified of the recommendation to increase the Glucerna 1.2 to 65 ml per hour until October 17, 2013.</p> <p>Medical record review of a Physician's Progress Note dated October 17, 2013, revealed "wt. (weight) loss noted but edema has improved dramatically...plan 1) (increase) TF (tube feeding) and monitor resident..."</p>	F 157	<p>providing a copy of all recommendations to the Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor and Administrator in addition to the Certified Dietary Manager. The Director of Nursing and/or Assistant Director of Nursing and Administrator will review the recommendations and follow up with the Certified Dietary Manager and nursing staff to ensure the physician is notified of recommendations timely.</p> <p>All licensed nurses will be reeducated by the Director of Nursing on the importance of following up on recommendation immediately by November 30, 2013.</p> <p>The Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will audit all resident's records that are seen by the Registered Dietitian weekly for 4 weeks then twice monthly for 3 months. Audits will be presented monthly in the Quality Assurance Process Improvement meeting November 30, 2013.</p>	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445481	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2013
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT			STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660		
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F 157	Continued From page 2 Observation on October 21, 2013, at 3:32 p.m., revealed the resident lying on the bed receiving Glucerna 1.2 at 85ml per hour. Interview on October 22, 2013, at 2:45 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the physician was not notified of the recommendation to increase the Glucerna to 65ml per hour until October 17, 2013.	F 157			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to assess the use of restraints for three (#138, #112, and #49) of twenty-three residents reviewed. The findings included: Resident #138 was admitted to the facility on October 15, 2013, with diagnoses including Aspiration Pneumonia, Atrial Fibrillation, Rheumatoid Arthritis, and Diabetes Mellitus. Medical record review of the Side Rail Assessment dated October 15, 2013, revealed the resident used the bed rails to assist in turning and repositioning.	F 221	F 221 Restraint assessments have been completed for residents #138, #112, and #49. Care plans for these residents have been updated accordingly. By November 30, 2013, the facility will have completed an audit on all beds by Assistant Director of Nursing and/or Registered Nurse Supervisor. Residents with two side rails in place that would be considered a restraint will be assessed using the restraint assessment form. All nursing staff will be educated to the use of side rails as positioning and safety devices and when they are considered restraints. Documentation requirements will be included in this education. This education will be completed by	11/30/2013	

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT			STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660		
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F 221	<p>Continued From page 3</p> <p>Review of the facility's policy Restraints-Physical dated December 2, 2004, revealed "...A physical restraint is defined as any article, device, or garment that is used primarily to modify resident behavior by interfering with free movement..."</p> <p>Observation on October 22, 2013, at 9:41 a.m., revealed the resident seated on the bed with one-half side rails raised in the mid-point of the bed.</p> <p>Interview on October 22, 2013, at 1:15 p.m., with the Assistant Director of Nursing (ADON), in the conference room, revealed the resident was able to exit the bed, and confirmed the one-half side rails raised in the mid-point of the bed, prevented the resident from exiting the bed in a normal manner, and confirmed the resident had not been assessed for the use of a restraint.</p> <p>Resident #112 was admitted to the facility on October 9, 2013, with diagnoses including Diarrhea, Urinary Tract Infection, and Dementia.</p> <p>Medical record review of a physician's order dated October 9, 2013, revealed "...Side rails up times 2 to aide in turning and repositioning..."</p> <p>Medical record review of the Side Rail Assessment dated October 9, 2013, revealed "...Medical symptom requiring usage of bed rails: weakness, confusion ...(up) x 2 to aid (turning and repositioning)..."</p> <p>Medical record review of the Physical Therapist Progress Note dated October 16, 2013, revealed "...able to safely complete all functional transfers requiring minimal assistance...able to safely transition from sit stand requiring minimal</p>	F 221	<p>November 30, 2013 by Assistant Director of Nursing.</p> <p>The Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will audit 2 resident's records per hall per week for 4 weeks to ensure residents are not restrained by side rails without proper assessment, communication and documentation. The Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will also ensure that the care plan reflects the reason for use of side rails and if an assessment is completed for the use of a restraint. Results of the audits will be presented monthly in the Quality Assurance Process Improvement meeting.</p>		

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IDENTIFICATION NUMBER:

445481

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

10/23/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ASBURY PLACE AT KINGSPORT

100 NETHERLAND LANE
KINGSPORT, TN 37660(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETION
DATE

F 221

Continued From page 4
assistance..."

Observation on October 22, 2013, at 2:45 p.m., revealed the resident lying on the bed with half side rails in the mid bed position raised bilaterally.

Interview on October 22, 2013 at 1:20 p.m., in the conference room, with the Assistant Director of Nursing, confirmed no assessment had been completed for the use of the siderails as a restraint.

Resident #49 was admitted to the facility on May 3, 2013, with diagnoses including Fractured Hip, Hypertension, Peripheral Vascular Disease, and Dementia.

Medical record review of the Side Rail Assessment dated August 15, 2013, revealed "...Does the resident use the bed rails to assist in turning and repositioning...yes...SR (side rails) (up) x 2..."

Medical record review revealed no restraint assessment for the side rails had been completed.

Observation on October 23, 2013, at 8:00 a.m., revealed the resident lying on the bed, with half side rails in the mid bed position raised bilaterally.

Interview on October 22, 2013, at 3:00 p.m. at the nursing station with Licensed Practical Nurse #1, confirmed the resident was able to self transfer from the bed to the wheelchair.

Interview on October 23, 2013, at 8:15 a.m., in the conference room, with the Assistant Director of Nursing, confirmed no assessment had been

F 221

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 446481	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2013
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT			STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660		
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F 221	Continued From page 5 completed for the use of the side rails as a restraint.	F 221			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure an	F 278	F 278 The care plan has been updated to reflect the condition of the resident's teeth with appropriate intervention. All residents will have a dental assessment completed by Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor by November 30, 2013. A new form will be placed in the admission packet for a dental assessment. All licensed staff will be reeducated by November 30, 2013 on the proper way to assess a resident's dental health. Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will audit all new admission's dental assessments for the next 4 weeks, and then 5 admissions each month. Audit results will be reported to the Quality Assurance Process Improvement committee.	11/30/2013	

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F 278	Continued From page 6 accurate assessment of dental status for one resident (#6) of twenty-three residents reviewed. The findings included: Resident #6 was admitted to the facility on August 30, 2013, with diagnoses including Aspiration Pneumonia, Dysphagia, Anemia, Hypertension, and Status Post Colostomy. Medical record review of the Resident-Data Collection form dated August 30, 2013, revealed the resident did not have any teeth or dentures. Medical record review of the admission Minimum Data Set (MDS) dated September 12, 2013, revealed no dental issues were identified. Observation on October 21, 2013, at 3:32 p.m., revealed the resident lying on the bed, with some missing upper teeth, and stated needed a root canal. Observation and interview on October 22, 2013, at 3:00 p.m., with the Director of Nursing (DON) revealed the resident lying on the bed, and the DON described the resident's teeth as appearing to have decay with some missing teeth. Interview on October 22, 2013, at 3:05 p.m., with the DON, in the DON's office confirmed the MDS dated September 12, 2013, did not reflect the resident's likely cavities and confirmed the Resident-Data Collection form dated August 30, 2013, was not accurate as the resident had teeth.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279			

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT			STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37680		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 7</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a care plan to address weight loss, depression, and anxiety for one (#6) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on August 30, 2013, with diagnoses including Aspiration Pneumonia, Dysphagia, Anemia, Hypertension, and Status Post Colostomy.</p> <p>Medical record review of a Registered Dietician (RD) note dated September 25, 2013, revealed</p>	F 279	<p>F 279</p> <p>The care plan for resident #6 now reflects issues and risks of weight loss, depression and anxiety. Appropriate interventions are also in place for this resident.</p> <p>By November 30, 2013 all licensed staff will be re-educated by the Director of Nursing on updating care plans and following up on recommendations from other practitioners/professionals.</p> <p>By December 31, 2013, all current resident care plans will have been reviewed by the Assistant Director of Nursing to ensure all care issues are included on the care plan.</p> <p>Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will perform weekly review of weights. Any change in nutritional status will be updated in the resident's care plan to reflect any change.</p> <p>Effective January 1, 2014, Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will perform audits on 2</p>	11/30/2013	

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT			STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660		
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F 279	<p>Continued From page 8</p> <p>"wt (weight) loss from 117.3 lbs to 102.6 lbs 9/22/13..."</p> <p>Medical record review revealed the resident weighed 95 lbs. on October 15, 2013.</p> <p>Medical record review of a psychiatric note dated September 2, 2013, revealed the resident was seen for mood and behaviors, anxiety, depressive signs and symptoms with recommendations for Zoloft (antidepressant) and to increase the as needed Xanax (anxiety).</p> <p>Medical record review of the Care Plan dated August 30, 2013, revealed no documentation of the resident's weight loss, depression, anxiety, or the possible side effects of the antidepressant and anxiety medications.</p> <p>Interview on October 23, 2013, at 9:55 a.m., with the Director of Nursing (DON), in the DON's office confirmed a Care Plan had not been developed to address the resident's weight loss.</p> <p>Interview on October 23, 2013, at 12:50 p.m., with the Director of Nursing, in the conference room, confirmed a care plan had not been developed to address the resident's depression, anxiety, or the possible side effects of the antidepressant and anxiety medications.</p>	F 279	<p>charts per hall per week for 4 weeks to ensure care plans reflect all care issues for the resident.</p> <p>Audit findings will be reported each week in Quality of Life/Quality of Care meeting to the Interdisciplinary Team and to the Quality Assurance Process Improvement monthly.</p>		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p>	F 280	<p>The use of the Personal Safety Alarm for resident #138 has now been placed on care plan. The care plan for resident #62 now reflects the use of the geri-chair for positioning.</p>	11/30/2013	

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F 280	<p>Continued From page 9</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview the facility failed to revise a care plan for a positioning device for one (#62), and for a safety alarm for one (#138) of twenty-three sampled residents.</p> <p>The findings included:</p> <p>Resident #62 was admitted to the facility on July 16, 2013, with diagnoses including Anemia, Alzheimer's Disease, Paralysis Agitans, and Depressive Disorder.</p> <p>Observation on October 22, 2013, at 2:00 p.m., revealed the resident in the resident's room sitting quietly in a geri-chair in a reclined position.</p> <p>Medical record review revealed therapy had assessed the resident on July 18, 2013, and the geri-chair was to be used as an assistive device</p>	F 280	<p>By November 30, 2013 all licensed staff will be re-educated on updating care plans and following up on recommendations from other practitioners/professionals by Assistant Director of Nursing (ADON).</p> <p>By December 31, 2013, all current resident care plans will have been reviewed by Director of Nursing, Assistant of Director of Nursing, or Registered Nurse Supervisor to ensure all care issues are included on the care plan.</p> <p>Effective January 1, 2014, Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will perform audits on 2 charts per hall per week for 4 weeks to ensure care plans reflect all care issues for the resident. Audit findings will be reported each week in Quality of Life/Quality of Care meeting to the Interdisciplinary Team and to the Quality Assurance Process Improvement monthly.</p>		

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STATEMENT OF DEFICIENCIES
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IDENTIFICATION NUMBER:

445401

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

10/23/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ASBURY PLACE AT KINGSPORT

100 NETHERLAND LANE

KINGSPORT, TN 37660

(X4) ID
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(EACH CORRECTIVE ACTION SHOULD BE
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DEFICIENCY)(X5)
COMPLETION
DATE

F 280

Continued From page 10
for positioning the resident.Review of the resident's current Care Plan Report
dated May 6, 2013, revealed no documentation
concerning the use of the geri-chair for
positioning.Interview with the Director of Nursing (DON) in
the DON's office on October 23, 2013, at 7:45
a.m., confirmed the care plan had not been
revised to include the geri-chair as a positioning
device.Resident #138 was admitted to the facility on
October 15, 2013, with diagnoses including
Aspiration Pneumonia, Atrial Fibrillation,
Rheumatoid Arthritis, and Diabetes Mellitus.Medical record review of a Fall Risk Evaluation
dated October 15, 2013, revealed the resident
was at high risk for falls.Review of a facility fall investigation dated
October 20, 2013, revealed the resident
experienced a fall, without injury, in the bathroom
at 3:00 p.m. Continued review of the fall
investigation revealed the resident had removed
the personal safety alarm (PSA) at the time of the
fall, and the PSA was to be placed where the
resident could not remove it.Observation on October 22, 2013, at 1:05 p.m.,
revealed the resident seated in a wheelchair, at
bedside, feeding self lunch, with a personal safety
alarm in place.Medical record review of the Care Plan dated
October 15, 2013, revealed the resident was at
risk for falls, however, there was no
documentation of the need for the PSA.

F 280

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445481	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2013
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NAME OF PROVIDER OR SUPPLIER

ASBURY PLACE AT KINGSPORT

STREET ADDRESS, CITY, STATE, ZIP CODE

100 NETHERLAND LANE
KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11	F 280		
F 281 SS=D	<p>Interview on October 22, 2013, at 1:40 p.m., with the Assistant Director of Nursing, in the conference room, confirmed the Care Plan had not been revised to include the need for the personal safety alarm.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain physician's orders for the size, care and frequency of changes for a urinary catheter for one (#14), of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #14 was re-admitted to the facility on September 25, 2013, with diagnoses including Dysphagia, Urinary Retention, and Stage 3 Chronic Kidney Disease.</p> <p>Medical record review revealed the resident was admitted with a #16 (size) urinary catheter. Continued review revealed no physician orders for the size, care, and frequency of changes for the urinary catheter.</p> <p>Observation on October 23, 2013, at 9:00 a.m., revealed the resident lying on the bed. Continued observation revealed the resident had a #16/30cc urinary catheter with yellow urine noted.</p>	<p>F 281</p> <p>A physician order has been obtained for the Foley catheter, size and frequency of changes for resident #14.</p> <p>All medical records for residents with Foley catheters will be audited by the Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor to ensure that the size, care and frequency of change is ordered by the physician. This review will be completed by November 30, 2013.</p> <p>All licensed staff will be reeducated on the need for documentation of reason for Foley catheter, size, care, and how often catheter is to be changed by November 30, 2014 by Director of Nursing.</p> <p>All new admissions for 4 weeks will be assessed by Assistant Director of Nursing or Registered Nurse Supervisor for use of Foley</p>	11/30/2013	

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT			STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37680		
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F 281	Continued From page 12	F 281	Catheters. If a catheter is present, the chart will be audited for evidence of a physician order for catheter, size, care and frequency of changes.		
F 309 SS=D	<p>Interview with the Director of Nursing (DON) in the DON's office on October 23, 2013, at 9:30 a.m., confirmed no physician orders were obtained as to catheter care, size, or schedule of catheter changes and care.</p> <p>463.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the physician's order regarding the pharmacy consultant's recommendation for one resident (#45) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #45 was admitted to the facility on July 6, 2012, with diagnoses including Hypertension, Hyperlipidemia, Anemia, Mental Disorder, Depressive Disorder, Anxiety State, Altered Mental State, Insomnia, Renal Cell Carcinoma, Arthritis, Diabetes Mellitus, and Delirium.</p> <p>Medical record review of the Medication Regimen Review dated August 30, 2013, revealed a recommendation by the Consultant Pharmacist to</p>	F 309	<p>The results of the audits will be reported by Director of Nursing to the Quality Assurance Process Improvement committee.</p> <p>F 309 The physician has addressed the pharmacy recommendation for resident #45.</p> <p>All charts will be audited by November 30, 2013 to make sure all pharmacy recommendations have been followed up on by the Director of Nursing.</p> <p>The Assistant Director of nursing and Registered Nurse Supervisor will be re-educated by Pharmacy Consultant about following up on pharmacy recommendations by November 30, 2013.</p> <p>Within 7 days of the pharmacist's visit and receipt of</p>	11/30/2013	

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F 309	<p>Continued From page 13</p> <p>"change Risperidone 0.25mg (milligrams) 1 (one) tab (tablet) po (by mouth) 9 pm to Risperidone 0.25mg one half tab po 9 pm as a trial GDR (gradual dose reduction)."</p> <p>Further review of the Medication Regimen Review dated August 30, 2013, revealed a signed written response from the attending physician, "ask Mental Health."</p> <p>Medical record review revealed, no documentation Mental Health had been notified related to the GDR.</p> <p>Medical record review of the Medication Report revealed, Resident #45 was currently receiving Risperidone 0.25mg one tablet every evening.</p> <p>Interview with the Assistant Director of Nursing on October 22, 2013, at 3:10 p.m., in the conference room, confirmed the facility had failed to follow the physician's orders and Mental Health had not seen Resident #45 regarding the gradual dose reduction of Risperidone.</p>	F 309	<p>recommendations, the Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will bring the file of recommendations to the Quality of Life /Quality of Care meeting for a second review to ensure that all recommendations have been addressed by the respective physician.</p> <p>Any recommendations that lack a response, will be managed within 48 hours of this second review.</p> <p>Completion date November 30, 2013.</p>		
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p>	F 325	<p>The Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will complete audits on 10% of medical records with pharmacy recommendations each month for 3 months.</p> <p>Results will be presented by the Director of Nursing at the Quality Assurance Process Improvement.</p>		

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F 325	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure an assessment was completed by a Registered Dietician for one (#112), and failed to ensure tube feedings were administered as ordered for one (#6) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #112 was admitted to the facility on October 9, 2013, with diagnoses including Diarrhea, Urinary Tract Infection, and Dementia.</p> <p>Medical record review of the Nutritional Assessment dated October 16, 2013, revealed "...Diet...Reg (regular) lactose free...wt. (weight) 86 (pounds) IBW (Ideal Body Weight)...105..."</p> <p>Medical record review of the GeriMenu Resident Memo File Printout dated October 16, 2013, revealed "...Weight on 10/10/13...86.0...Res (resident) is 19 (pounds) (below)...ibw...intake of food (and) fluids served, 75%...Will monitor intake of food (and) fluids served..."</p> <p>Medical record review of a laboratory report dated October 14, 2013, revealed "...Total Protein 5.9...Ref (reference) Ranges...6.4-8.2...Albumin 3.0...Ref Ranges 3.4-5.0..."</p> <p>Medical record review of the Resident Weight Report dated October 23, 2013, revealed the resident's weight was 87 pounds.</p> <p>Review of the ADL (Activities Daily Living)</p>	F 325	<p>F 325</p> <p>The Registered Dietitian has been consulted for resident #112 and recommendations have been reviewed by the physician and implemented. This resident's weight has stabilized.</p> <p>A new form used to record all tube feeding amounts and flush amounts by shift has been designed and placed on the front of the Medication Administration Record for resident #6.</p> <p>A new process has been put in place on how Registered Dietitian notifies Director of Nursing, Assistant Director of Nursing, and/or Registered Nurse Supervisor and Administrator of Registered Dietitian recommendations. Nursing and dietary will review significant weight changes and determine appropriate interventions within 7 days.</p> <p>The process change includes the Registered Dietitian providing a copy of all recommendations to the Director of Nursing, Assistant Director of Nursing and/or</p>	11/30/2013	

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100 NETHERLAND LANE
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F 325	<p>Continued From page 15</p> <p>Verification Worksheet dated October 9, 2013, through October 22, 2013, revealed the resident's meal intake varied from 50% to 100%.</p> <p>Observation on October 23, 2013, at 7:55 a.m. revealed the resident seated in a wheelchair, in the resident's room, being fed eggs, oatmeal and sausage by the resident's family member. The resident's family member stated the resident eats a good breakfast.</p> <p>Observation on October 23, 2013, at 1:00 p.m. revealed the resident ate approximately 3/4 hamburger, all of the strawberries, and a few carrots.</p> <p>Interview on October 23, 2013, at 10:40 a.m., with the Certified Dietary Manager, in the conference room, revealed the Registered Dietician (RD) was to be notified of residents below IBW with low protein and albumin and confirmed the Registered Dietician had not been notified.</p> <p>Resident #6 was admitted to the facility on August 30, 2013, with diagnoses including Aspiration Pneumonia, Dysphagia, Anemia, Hypertension, and Status Post Colostomy.</p> <p>Medical record review of the nursing notes dated August 31, 2013, revealed the resident had four plus ankle edema.</p> <p>Medical record review of a Nutritional Assessment dated September 3, 2013, revealed the resident was 5' 3" tall and weighed 117 lbs., the resident received nothing by mouth, received tube feedings of Glucerna 1.2 at 55 ml (milliliters) per hour, twenty-four hours daily with saline</p>	F 325	<p>Registered Nurse Supervisor and Administrator in addition to the Certified Dietary Manager. The Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor and Administrator will review the recommendations and follow up with the Certified Dietary Manager and nursing staff to ensure the physician is notified of recommendations timely.</p> <p>A new form used to record all tube feeding amounts and flush amounts by shift has been designed and placed on front of each Medication Administration Record for all patients receiving a tube feeding educated by Director of Nursing. The Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor and Certified Dietary Manager will perform weekly review of weights and Intake Output report on each resident to ensure all nutritional status changes are addressed.</p>	

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F 325	<p>Continued From page 16</p> <p>flushes of 50 ml, four times a day.</p> <p>Medical record review of a High Risk Follow-Up note by the Registered Dietician (RD) dated September 4, 2013, revealed the resident was NPO (nothing by mouth), received Glucerna 1.2 at 55 ml per hour by feeding tube, was tolerating the tube feedings, was admitted with some edema, the tube feeding was meeting the resident's needs and there were no new recommendations.</p> <p>Medical record review of an RD note dated September 25, 2013, revealed "wt (weight) loss from 117.3 lbs to 102.6 lbs 9/22/13...Recommend to increase TF (tube feeding) rate to 65cc/hr continuous. This would increase calories to 1872/24 hrs. Water flush 100cc q 4 hrs. Goal = stop wt loss."</p> <p>Medical record review revealed the resident weighed 95 lbs. on October 15, 2013.</p> <p>Medical record review revealed no documentation the physician had been notified of the recommendation to increase the Glucerna to 65 ml per hour until October 17, 2013.</p> <p>Medical record review of a Physician's Progress Note dated October 17, 2013, revealed "wt. (weight) loss noted but edema has improved dramatically...plan 1) (Increase) TF (tube feeding and monitor resident..."</p> <p>Medical record review of a physician's order dated October 17, 2013, revealed "...lymphedema...lower extremities. Increase TF (tube feeding) to 60cc hr. (hour) if tolerate well...may increase to 65cc/hr..."</p>	F 375	<p>The Certified Dietary Manager has started care planning all dietary changes. Weekly reviews of dietary changes will be discussed in Quality of Life/Quality of Care meetings.</p> <p>Weight reports will be printed weekly and reviewed by Director of Nursing, Assisted Director of Nursing and/or Registered Nurse Supervisor and Certified Dietary Manager.</p> <p>The results will be presented by the Director of Nursing to Quality Assurance Process Improvement committee monthly.</p>	

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F 325	<p>Continued From page 17</p> <p>Observation on October 21, 2013, at 3:32 p.m., revealed the resident lying on the bed receiving Glucerna 1.2 at 65cc per hour.</p> <p>Interview on October 22, 2013, at 2:45 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the physician was not notified of the recommendation to increase the Glucerna to 65cc per hour until October 17, 2013.</p> <p>Medical record review revealed the total amount of tube feeding administered to the resident was not documented.</p> <p>Observation on October 22, 2013, at 4:25 p.m., revealed the resident in the hallway, seated in a wheelchair. Continued observation revealed the resident was not receiving tube feeding.</p> <p>Observation on October 23, 2013, at 9:40 a.m., revealed the resident receiving hair care in the facility beauty shop, and was not receiving tube feeding.</p> <p>Interview on October 23, 2013, at 10:00 a.m., with Licensed Practical Nurse (LPN) #2, at the nursing station, (LPN responsible for the care of resident #6), revealed the resident did not receive the tube feeding as ordered by the physician for approximately three to three and one-half hours daily due to the resident being out of bed.</p> <p>Interview on October 23, 2013, at 10:10 a.m., with the DON, in the DON's office, confirmed the resident's tube feeding intake was not documented/monitored to ensure the resident received the appropriate amount of tube feeding.</p>	F 325		

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F 325	Continued From page 18 Telephone interview on October 23, 2013, at 10:20 a.m., with the physician, revealed the resident had severe Gastroparesis and a Hiatal Hernia, and bolus feedings were not appropriate for the resident. Continued interview revealed the resident's lower extremities were very swollen upon admission to the facility, and the edema had dramatically improved and could account for the resident's weight loss.	F 325			
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain dental services for one (#6) of twenty-three residents reviewed. The findings included: Resident #6 was admitted to the facility on August	F 411	F 411 Resident #6 was asked if they had pain and they said no. They were offered dental services and they declined the offer. All residents will be assessed for need of dental services by November 30, 2013. An oral assessment will be completed on all new admissions and they will be asked if they have dental pain as well as if they would like to see a dentist. Arrangements will be made to transport to dentist if resident wishes to see the dentist. The mobile dental service will continue to visit every 6 months. All licensed nurses will be reeducated on mouth and dental assessments by November 30, 2013 by a Registered Nurse.	11/30/2013	

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F 411	<p>Continued From page 19</p> <p>30, 2013, with diagnoses including Aspiration Pneumonia, Dysphagia, Anemia, Hypertension, and Status Post Colostomy.</p> <p>Medical record review of the Resident Data Collection form dated August 30, 2013, revealed the resident did not have any teeth or dentures.</p> <p>Medical record review of the admission Minimum Data Set dated September 12, 2013, revealed no dental issues were identified.</p> <p>Observation and interview on October 21, 2013, at 3:32 p.m., revealed the resident lying on the bed, with missing upper teeth, and stated needed a root canal. Continued interview with the resident revealed the resident was not experiencing any tooth pain.</p> <p>Observation and interview on Oct 22, 2013, at 3:00 p.m., with the Director of Nursing (DON) revealed the resident lying on the bed, and the DON described the resident's teeth as appearing to have decay with some missing teeth.</p> <p>Interview on October 22, 2013, at 3:05 p.m., with the DON, in the DON's office confirmed there had been no dental consultation arranged for the resident since admission.</p>	F 411	<p>A new more in-depth form will be used to assess dental health and the need for intervention by a dentist. Form will be completed upon admission and every six months.</p> <p>Dental/oral assessments will be audited by Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor. Two charts per hall per week for 4 weeks, then two per hall monthly for 2 months.</p> <p>Findings of the dental/oral assessment audit will be reported to Quality Assurance Improvement Process monthly by Director of Nursing.</p>		